Instructions to Claimants – *New York City Disaster Area*
Gathering and Submitting Information from Private Physicians

The September 11th Victim Compensation Fund ("VCF") works closely with the World Trade Center ("WTC") Health Program to determine whether a claimant's medical condition(s) can be certified as eligible for compensation from the VCF. For claimants who are being treated by private physicians outside of the WTC Health Program, the VCF gathers the claimant's medical and exposure information and submits it to the WTC Health Program for review. ***Without information from the WTC Health program or a claimant's treating physician, the VCF cannot deem a claimant eligible for compensation***. Please follow the instructions below and use the enclosed documents to gather the information the VCF needs in order to verify the claimed condition is eligible for compensation.

Step 1: Review the enclosed documents to understand the type of information that is needed. The documents can also be found on the www.vcf.gov website under "Forms and Resources". The website also has Frequently Asked Questions ("FAQs") about the Private Physician process.

Step 2: Review in detail the "*Assessing Exposure to the September 11th, 2001 Attacks Form"* and complete the form, being careful to use either the Responder or Non-Responder version based on the claimant's specific circumstances.

Step 3: Review the WTC Health Program "*Diagnostic Essentials: Physical Health Condition*s" document. ***The guidelines outline the specific documentation that is required in order to verify a condition for compensation from the VCF***. Review the required documents for the specific injury being claimed to confirm you will be able to provide the requested information.

Step 4: Complete the 2-page "*Treating Physician Information Form"* using a separate form for each treating physician. This form can be completed by the claimant or the physician. Please list the conditions for which the claimant is being treated and the year of earliest diagnosis/symptom and provide relevant medical records (as outlined in the "Diagnostic Essentials" document) that support the diagnosis. If the claimant completes the form, please notify the physician that the form has been submitted to the VCF.

Step 5: Complete an "*Authorization for Release of Medical Records Form*" for *each* physician whose information is included in a "*Treating Physician Information Form"*. Provide one original version of the Authorization Form to the individual physician and send a second original version to the VCF. It is important that you complete one Authorization for each physician and provide the completed, original Authorization forms to both the VCF and your physician(s). The Authorization Form authorizes the physician(s) to speak with the VCF about the claimant's treatment. Please note there is one version of the form for Personal Injury claimants and one version for those filing a claim on behalf of a Deceased Individual.

Step 6: Gather the completed forms and relevant records from each physician and write the claimant's name and VCF claim number on the first page of *each* form or document. Finally, complete the "*Cover Sheet for Return of Completed Private Physician Forms*" and upload the cover sheet and documents to the online claim or mail them in a single package to the VCF at:

September 11th Victim Compensation Fund
PO Box 34500
Washington, DC 20043

For overnight deliveries:
September 11th Victim Compensation Fund
1220 L Street NW
Suite 100 - Box 408
Washington, DC 20005-4018

When uploading the forms to your online claim, please select "Private Physician Forms" from the list of document types. Please do <u>not</u> upload or mail the documents separately. It will speed processing if all of the documents for a single claim are uploaded at the same time or sent as one package to the VCF.

Cover Sheet for Return of Completed Private Physician Forms, Associated Records, and Assessing Exposure Worksheets

Claimant Name: _____

Claim Number: VCF __ __ __ __ __ __ __

Please complete this form and include it with the Private Physician forms and relevant documents that are uploaded to the online claim or mailed to the VCF. This form notifies the VCF that all of the applicable documents have been received for the claim. For claimants who have one or more physicians who will mail the information directly to the VCF, this form identifies the physician(s) and notifies the VCF that the documents will be submitted.

When uploading the forms to your online claim, please select "Private Physician Forms" from the list of document types. This will help ensure your forms are properly categorized for faster processing. Please see FAQ #4.12 on the ww.vcf.gov website for step-by-step instructions for uploading documents to your claim.

**** Claimants should submit the completed forms and relevant records in ONE package or upload the documents to the claim at the same time *unless the physician is mailing the information directly to the VCF.* ****

☐ Check here if this package includes all information and documents the claimant expects to submit to the VCF regarding treatment by physicians outside of the WTC Health Program.

☐ Check here if this package includes all physician information and documents being submitted by the claimant, but additional documents will be mailed directly to the VCF by the physician(s). If selecting this option, please indicate in the spaces below the names of the physicians who will mail documents to the VCF.

☐ Check here if all information and documents will be sent to the VCF directly by the physicians (claimant will not submit any additional forms beyond those submitted by physicians). If selecting this option, please indicate in the spaces below the names of the physicians who will mail forms to the VCF.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Assessing Exposure to the September 11, 2001 Attacks - *NYC Disaster Area*

Complete this form if you were present in the NYC Disaster Area. If you were present at the Pentagon or Shanksville, PA sites, please use the version of the form specific to those sites.

For the purposes of completing this form, please use the following definitions:

- A **Responder** is a worker or volunteer who provided rescue, recovery, demolition, debris removal, and related support services in the aftermath of the September 11, 2001 attacks on the World Trade Center.
- A **Non-Responder** is a person who was present in the "NYC disaster area"[1] in the aftermath of the September 11, 2001, terrorist attacks on the World Trade Center as a result of their work, residence, or attendance at school, childcare, or adult daycare.

- *If the Claimant was a **Responder** in the NYC disaster area, begin completing the form on this page.*
- *If the Claimant was a **Non-Responder** in the NYC disaster area, complete the form starting on page 6.*

* *

Claimant's Name: _____

VCF Claim Number: VCF_____

1. **Dates of response and recovery service (MM/DD/YYYY):**

   Start: _____ Finish: _____

   Comments (optional):

2. **Indicate in the below chart the estimated total duration of exposure for the different relevant exposure timeframes. Total duration of exposure is the number of hours that the Claimant performed rescue, recovery, demolition, debris removal, and related support services ("Response Activities") while within the NYC disaster area.**

Relevant Exposure Timeframes				Estimated Total Duration
September 11, 2001	☒ Not present	☐ < 1 hour	☐ ≥ 1 hour	Estimated duration in hours
September 12 – 14, 2001	☐ Not present	☐ < 4 hours	☐ ≥ 4 hours	Estimated duration in hours
September 15 – 30, 2001	☐ Not present	☐ < 24 hours	☐ ≥ 24 hours	Estimated duration in hours
October 1, 2001 – May 30, 2002	☐ Not present	☐ < 80 hours	☐ ≥ 80 hours	Estimated duration in hours

[1] The NYC disaster area consists of the area in Manhattan south of the line that runs along Canal Street from the Hudson River to the intersection of Canal Street and East Broadway, north on East Broadway to Clinton Street, and east on Clinton Street to the East River; AND any area related to, or along, routes of debris removal, such as barges and Fresh Kills.

3. Indicate in the chart on the following page the location(s) where the Claimant performed Response Activities and the jobs/tasks performed by the Claimant. There are two columns that must be filled-in for the chart.

i) In the column "**Location(s) of Response Activities**", indicate the location(s) that the Claimant performed Response Activities during the time period by selecting the corresponding code(s) of the locations listed below.

Location Code	Location
A	On the pile/in the pit
B	Adjacent to the pile/pit
C	Landfill
D	Barges/loading piers
E	Elsewhere south of Canal Street
F	Other location – specify:
G	Don't know

ii) In the column "**Jobs/Tasks Performed**", indicate the specific jobs/tasks performed by the Claimant during the time period by selecting the corresponding code(s) from the jobs/tasks listed below.

Job/Task Code	Job/Task Performed	Job/Task Code	Job/Task Performed
01	Body bag work	14	Industrial hygiene
02	Bucket brigade	15	Morgue work
03	Cable installation/repair/ splicing (excluding work performed in manholes)	16	Perimeter security
04	Cable installation/repair/ splicing (including work performed in manholes)	17	Sanitation worker
05	Canteen services	18	Search and rescue
06	Counselor	19	Sifting (excluding conveyor belt)
07	Custodian	20	Sifting (including conveyor belt)
08	Dog Handler	21	Towing
09	Dust suppression	22	Truck loading/unloading
10	EMT	23	Truck routing
11	Escorting	24	Torch cutting or burning
12	Excavation/confined space work	25	Work with concrete
13	Fire Fighter	26	Other; **Specify**:

Time Period	Location(s) of Claimant's Response Activities (Location Code)	Jobs/Tasks Performed (Job/Task Code)
September 11, 2001	A B C D E F G	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
September 12-14, 2001	A B C D E F G	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
September 15-30, 2001	A B C D E F G	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
October 1-December 31, 2001	A B C D E F G	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
January 1-May 30, 2002	A B C D E F G	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26

In the table below, indicate the relative amount of dust/fume/smoke exposure while performing the jobs/tasks described above for each time period listed. Place an "X" in the appropriate box(es) in the table.

	Relative Amount of Dust/Fume/Smoke Exposure		
Time Period during which Jobs/Tasks were Performed	Heavy visible layer of dust and/or smell of WTC smoke	Light visible layer of dust and/or smell of WTC smoke	No visible layer of dust and/or smell of WTC Smoke
September 11, 2001	☐	☐	☐
September 12-14, 2001	☐	☐	☐
September 15-30, 2001	☐	☐	☐
October 1-December 31, 2001	☐	☐	☐
January 1-May 30, 2002	☐	☐	☐

4. Identify the Claimant's location of residence, school or non-Response Activities work if also located within the NYC disaster area for each time period listed below.

Time Period	Activity (e.g., live, school, work) - if worked, describe job tasks	Location
September 11, 2001		
September 12-14, 2001		
September 15-30, 2001		
October 1-December 31, 2001		
January 1-May 30, 2002		

(*Continued on next page*)

5. Was the Claimant in the NYC disaster area at any time on September 11, 2001?

☐ Yes ☐ No

If yes – then check any relevant descriptions below:

☐ Directly in the cloud of dust (or "blackout") from the collapse of the WTC buildings

☐ Exposed to significant amounts of dust but not directly in the cloud of dust from the collapse of the WTC buildings

☐ Exposed to some dust but not in the cloud of dust from the collapse of the WTC buildings

☐ Not exposed to dust and not in the cloud of dust from the collapse of the WTC buildings

☐ Don't know

If yes – what was the specific location of the Claimant's response activity **ON** September 11, 2001?

***** End of Responder – NYC Form *****

*Please begin here if the Claimant was a **Non-Responder** in the NYC disaster area. If the Claimant was a Responder in the NYC disaster area, please complete the form for Responders starting on page 1.*

Claimant's Name: _____

VCF Claim Number: VCF_____

1. **Indicate in the below chart the total hours present in the NYC disaster area and the total hours spent at home, work or school if the Claimant's home, work or school was located within the NYC disaster area for each time period listed below.**

Time Period	Total hours present in the NYC disaster area	Total hours spent at home (if home was located within the NYC disaster area)	Total hours spent at work (if work was located within the NYC disaster area)	Total hours spent at school (if school was located within the NYC disaster area)
September 11, 2001				
September 12-14, 2001				
September 15-30, 2001				
October 1-December 31, 2001				
January 1-May 30, 2002				

2. **Indicate the Claimant's location(s) within the NYC disaster area and the activities performed by the Claimant while present in the NYC disaster area for each time period listed in the chart on the following page. There are three columns that must be filled-in for the chart.**

   i) In the column "**Location(s) of Non-Responder**", indicate the Claimant's location(s) within the NYC disaster area during the time period by selecting the corresponding code(s) from the locations listed below. Also specify the exact address within the NYC disaster area for the location(s).

Location Code	Location
A	Worker in one of the WTC towers
B	Worker in surrounding offices, stores, restaurants, or other workplace
C	Patron of surrounding stores, offices, or restaurants
D	Student or staff at school or preschool
E	Adult in daycare or staff at a daycare center
F	In transit; **Describe**:
G	At place of residence
H	Other location: **Specify**:

ii) In the column "**Activities Performed**", describe the activity(ies) performed by the Claimant while present in the NYC disaster area during the time period (e.g., cleaned home, cleaned workplace, lived in home).

iii) In the column "**Duration**", provide the duration that the Claimant performed the activity(ies) in the NYC disaster area during the time period.

Time Period	Locations of Non-Responder (Location Code)	Description of Activities Performed	Duration (total hours)
September 11, 2001	A B C D E F G H		
September 12-14, 2001	A B C D E F G H		
September 15-30, 2001	A B C D E F G H		
October 1-December 31, 2001	A B C D E F G H		
January 1-May 30, 2002	A B C D E F G H		

In the table below, indicate the relative amount of dust/fume/smoke exposure while performing the activities described above for each time period listed. Place an "X" in the appropriate box(es) in the table.

	Relative Amount of Dust/Fume/Smoke Exposure		
Time Period during which Activities were Performed	Heavy visible layer of dust and/or smell of WTC smoke	Light visible layer of dust and/or smell of WTC smoke	No visible layer of dust and/or smell of WTC Smoke
September 11, 2001	☐	☐	☐
September 12-14, 2001	☐	☐	☐
September 15-30, 2001	☐	☐	☐
October 1-December 31, 2001	☐	☐	☐
January 1-May 30, 2002	☐	☐	☐

3. Was the Claimant in the NYC disaster area at any time on September 11, 2001?

☐ Yes ☐ No

If yes – then please check the appropriate descriptions below.

☐ Directly in the cloud of dust (or "blackout") from the collapse of the WTC buildings

☐ Exposed to significant amounts of dust but not directly in the cloud of dust from the collapse of the WTC buildings

☐ Exposed to some dust but not in the cloud of dust from the collapse of the WTC buildings

☐ Not exposed to dust and not in the cloud of dust from the collapse of the WTC buildings

☐ Don't know

If yes, please provide the Specific location:

***** End of Non-Responder – NYC Form *****

Treating Physician Information Form

***** This form may be completed by the Physician or the Claimant *****
Please complete a separate version of this form for each treating physician.

Claimant Name: _____

VCF Claim Number: **VCF** __ __ __ __ __ __ __

Physician Name: _____

In the below chart, list the conditions for which the claimant is currently being (or previously was) treated by the physician. For each condition, provide the earliest date (month and year) of symptom onset and the date of first diagnosis (month and year).

Please provide copies of relevant records to support the diagnoses for the conditions listed below and any other information that might be relevant to the VCF, such as the effect of the condition(s) on the claimant. ***Please refer to the "Diagnostic Essentials: Physical Health Conditions"*** **document for the type of information that is required in order to verify a condition for compensation from the VCF.**

If applicable, please also provide a summary of any complications of treatment (i.e., new diagnoses stemming from treatment) and provide applicable medical records.

Condition Treated	Earliest Date of Symptom Onset (month/year)	Date of First Diagnosis (month/year)

Treating Physician Contact Information

***** This form may be completed by the Physician or the Claimant *****
Please complete a separate version of this form for each treating physician.

Claimant Name: _____

VCF Claim Number: **VCF**__ __ __ __ __ __ __

Physician Name: _____

Physician Address: _____

City_____**State**____ **Zip**_____

Physician Phone: **(**_____**)**_____

Physician Fax: **(** _____**)**_____

Physician Email: _____

Please also provide the state(s) where the physician is licensed to practice medicine, the corresponding license number(s) and any practice specialties along with the corresponding AMA Physician Specialty Code.

State(s) and license number(s):

_____

_____

Specialties and AMA Physician Specialty Codes:

_____

_____

_____

Diagnostic Essentials: Physical Health Conditions

World Trade Center Health Program

Issued: 18 December 2013
Revised: 2 April 2014
Revised: September 24, 2014
Revised: October 3, 2014
Revised: October 6, 2014

Health Condition Category[1]	Diagnostic Information Needed for Physician Determination[2]	Medical Basis
Interstitial Lung Disease[3]	• History (Symptoms) & Physical Exam Findings • PFTs/Spirometry • Radiographic/Imaging Evidence* and/or • Tissue Pathology Evidence* ● ***Note:*** For Sarcoidosis, tissue pathology* evidence is necessary to verify the diagnosis.	• American Thoracic Society(ATS)/European Respiratory Society International Multidisciplinary Consensus Classification of the Idiopathic Interstitial Pneumonias (2002) http://www.thoracic.org/statements/resources/interstitial-lung-disease/idio02.pdf • An Official American Thoracic Society(ATS)/European Respiratory Society Statement: Update of the International Multidisciplinary Classification of the Idiopathic Interstitial Pneumonias (2013) http://www.thoracic.org/statements/resources/interstitial-lung-disease/classification-of-IIPs.pdf • ATS Statement on Sarcoidosis (1999) http://www.thoracic.org/statements/resources/interstitial-lung-disease/sarcoid1-20.pdf

[1]The general categories of health conditions that are listed in this Table have been drawn from the List of Health Conditions for Responders found at 42 U.S.C. §§ 300mm-22(a)(3)(A) and 300mm—32(b)(1).

[2]In general, the diagnosis of a health condition depends on history, physical examination, and various types of diagnostic testing, including radiographic and other types of imaging, spirometry, and various laboratory and pathologic analyses, For each category of health conditions in this Table, a star superscript (*****) is listed next to the types of information that are essential for physician determination. In some categories, the clinician has a choice of which type of essential information is available in the medical record. Other clinical information that is not listed with a star superscript (*****) will support a diagnosis of a health condition.

[3]Interstitial lung disease is a broad category of lung diseases that includes more than 100 health conditions characterized by inflammation and/or fibrosis of the lungs. Some of the health conditions include, but are not limited to, idiopathic pulmonary fibrosis, hypersensitivity pneumonitis, sarcoidosis, eosinophilic granuloma, pulmonary vasculitis, bronchiolitis obliterans, connective tissue or autoimmune disease-related pulmonary fibrosis. See Schwartz, M.I., King, T.E. Interstitial Lung Disease, China: People's Medical Publishing House (2010).

Obstructive lung disease, excluding asthma and reactive airways disease[4]	• History (Symptoms) & Physical Exam Findings* and/or • PFTs/Spirometry* • Radiographic/imaging • ***Note:*** For WTC-exacerbated Chronic Obstructive Lung Disease (COPD), there must be evidence that COPD was present prior to September 11, 2001.[5]	• Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper (2004) http://www.thoracic.org/statements/resources/copd/copdexecsum.pdf • Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline from the American College of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society (2011) http://www.thoracic.org/statements/resources/copd/179full.pdf
Obstructive lung disease—asthma and reactive airways disease only	• History (Symptoms) & Physical Exam Findings* and/or • PFTs/Spirometry*	• NIH National Heart, Lung and Blood Institute (NHLBI) Guidelines for the Diagnosis and Treatment of Asthma -EPR-3 (2007) http://www.nhlbi.nih.gov/guidelines/asthma/
Upper Airway Inflammatory Disorders[6]	• History (Symptoms) & Physical Exam Findings* • Radiographic/imaging (CT of the sinuses)	• American Association of Family Physicians Diagnosing Rhinitis: Allergic vs. Nonallergic (2006) http://www.aafp.org/afp/2006/0501/p1583.html • American Academy of Otolaryngology/Head and Neck Surgery. Clinical Practice Guidelines on Adult Sinusitis http://oto.sagepub.com/content/137/3/365.full
Gastroesophageal Reflux Disorder	• History (Symptoms) & Physical Findings* and/or • Response to therapy* and/or • Endoscopic evidence of esophagitis, stricture or Barrett's metaplasia*	• American Gastroenterological Association (AGA) Medical Position Statement on the Management of Gastroesophageal Reflux Disease http://www.gastrojournal.org/article/S0016-5085(08)01606-5/fulltext

[4] Obstructive lung disease is a broad category of lung diseases which are characterized by varying degrees of reversible and irreversible airways obstruction and include chronic respiratory disorder (fumes/vapors),chronic cough syndrome, WTC-exacerbated chronic obstructive lung disease, asthma, and reactive airways dysfunction syndrome (RADS).

[5] Evidence consists of one of the following: (1) a record of physician diagnosis of COPD made prior to the individual's 9/11 exposure; (2) history of symptoms of chronic cough, sputum production and/or dyspnea experienced prior to the individual's 9/11 exposure; (3) a history of recurrent bronchopulmonary infections experienced prior to the individual's 9/11 exposure; (4) a record of pulmonary function tests showing chronic airways obstruction existing prior to the individual's 9/11 exposure; and (5) a record of imaging studies consistent with COPD existing prior to the individual's 9/11 exposure.

[6]Upper airway health conditions is a broad category of health conditions that include, and are limited to, chronic rhinosinusitis, chronic rhinitis, chronic nasopharyngitis, chronic laryngitis, and upper airway hyperactivity.

Obstructive Sleep Apnea exacerbated by, or related to, a health condition in this Table, excluding MSDs and Malignant Neoplasms	• History (Symptoms) & Physical Findings • Polysomnogram (PSG)/Sleep Study shows evidence of Obstructive Sleep Apnea *	• American Academy of Sleep Medicine(AASM) Clinical Guideline for the Evaluation, Management and Long-term Care of Obstructive Sleep Apnea in Adults http://www.aasmnet.org/Resources/clinicalguidelines/OSA_Adults.pdf
Musculoskeletal Disorders (MSDs)[7]	• History (Symptoms) & Physical Findings* and/or • Radiographic/Imaging Evidence* and/or • Electrodiagnostic testing (e.g., Electromyography and Nerve Conduction Velocity study)	• American Academy of Orthopedic Surgeons (AAOS) Endorsed Guideline - American Pain Society Clinical Guideline for the Evaluation and Management of Low Back Pain (Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society) http://annals.org/article.aspx?articleid=736814 • American Academy of Orthopedic Surgeons(AAOS) Diagnosis of Carpal Tunnel Syndrome Clinical Practice Guidelines (CPG) http://www.aaos.org/research/guidelines/CTS_guideline.pdf
Malignant Neoplasm	• History (Symptoms) & Physical Findings • Radiographic/Imaging Evidence • Chemistry Laboratory • Tissue biopsy/pathology report* ***Exception**:* Tissue biopsy is not required for selected neoplasms. See NCCN guidelines. ***Note***: When the diagnosis under review is metastatic neoplasm of an unknown primary, a diagnostic work-up summary is required to demonstrate that an appropriate search for the primary malignancy was done. Metastatic neoplasms with an unknown primary site shall be classified as neoplasms of the metastatic site. Latency shall be based on the date of diagnosis of the metastatic neoplasm, usually 4 years.	• National Comprehensive Cancer Network (NCCN) guidelines (http://www.nccn.org/professionals/physician_gls/f_guidelines.asp • National Cancer Institute (NCI) http://www.cancer.gov/cancertopics/factsheet/detection/pathology-reports • Borowitz M, Westra W, Cooley LD, et al. Pathology and laboratory medicine. In: Abeloff MD, Armitage JO, Niederhuber JE, Kastan MB, McKenna WG, editors. *Clinical Oncology*. 3rd ed. London: Churchill Livingstone, 2004.

[7]In the case of a WTC responder only (i.e., not in the case of a survivor) who received any treatment for a WTC-related musculoskeletal disorder *on or before September 11, 2003*, the list of health conditions that can be verified includes: (1) low back pain; (2) carpal tunnel syndrome (CTS); and (3) other musculoskeletal disorders. The term 'WTC-related musculoskeletal disorder' means a chronic or recurrent disorder of the musculoskeletal system caused by *heavy lifting* or *repetitive strain* on the joints or musculoskeletal system occurring during rescue or recovery efforts in the New York City disaster area in the aftermath of the September 11, 2001, terrorist attacks. See 42 U.S.C. § 300mm-22(a)(4).

OMB 1105-0092

Claimant's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Instructions for Claimant - Please list all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Then, please print your name and address and sign in the block in Section 2. Once you have completed and signed this authorization, please make a copy of your signed form and maintain it with your personal records.

When you sign this document, you give permission to your doctors, health care providers or other entities listed below to disclose your health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)[1] for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose your health information to the WTC Health Program and to the WTC Health Program to disclose your health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that the VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form.[2] This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

Your doctors and medical providers may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. However, the VCF may not be able to evaluate your claim if you do not authorize the release of your medical records. Your decision to sign or not sign this authorization also has no impact on your eligibility for enrollment, monitoring, treatment, or other WTC Health Program benefits.

Your providers and certain other entities are required by the Privacy Rule under HIPAA to protect your health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of your medical records to the extent they are permitted to do so under another Federal law, the Privacy Act.[3] The VCF will not disclose your identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed by your health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to your doctors and medical care providers by other health care providers. Your health care

[1] For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program.
[2] If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange your health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.
[3] The WTC Health Program will protect your health information pursuant to HIPAA and/or any other relevant laws and regulations.

OMB 1105-0092

Claimant's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating your VCF claim. This information includes, but is not limited to, whether you are a member of the WTC Health Program, and if so, where you receive your WTC Health Program health care benefits; whether you have been certified for treatment under the WTC Health Program; the number of and specific conditions for which you have been certified for treatment under the WTC Health Program; and information relating to payment of claims for treatment and pharmaceuticals received under the WTC Health Program.

Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the VCF.

I understand that this authorization is voluntary. However, if you refuse to sign this authorization, the VCF will not be able to process your claim for compensation.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information. Initial here:

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the claimant listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities.

Physician/Other Entity or Program:

Doctor/Provider/Entity Name

Doctor/Provider/Entity Address

Doctor/Provider/Entity Address continued

Suite Number

City

State/Province

Zip/Postal Code

( ) -

Telephone Number

Email Address

OMB 1105-0092

Claimant's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Section 2 - Claimant information and signature.

Claimant's Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Social Security or National ID Number

Date of Birth (mm/dd/yyyy)

Telephone Number (Home)

Telephone Number (Work)

Telephone Number (Mobile)

Email Address

This information shall be sent to:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

OMB 1105-0092

Claimant's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Section 2 - Claimant information and signature continued.

I Certify that I am the person named below (Claimant to the Victim Compensation Fund or Authorized Representative of the Claimant) and I authorize the release of information listed above, including disclosure of information by the WTC Health Program to the VCF, for the purposes of evaluating my claim for compensation under the VCF. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

Signature of Claimant or Authorized Representative(s)

Date (mm/dd/yyyy)

Print Name

Relationship to Claimant

Type of coverage to which this authorization applies (the doctor, health care provider or other entity will indicate all that apply)

- ◯ Medical
- ◯ Disability
- ◯ Pharmacy
- ◯ Long Term Care
- ◯ Other. Please specify/describe.